Group Insurance Commission's Pre-Tax Programs

Health Care Spending Account (HCSA) & Dependent Care Assistance Program (DCAP)

Sentinel BENEFITS

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Participant Handbook - Calendar Year 2005

The Commonwealth of Massachusetts' Group Insurance Commission (GIC) sponsors two tax-saving reimbursement accounts. Authorized by Section 125 of the Internal Revenue Service (IRS) Code, the Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP) allow you to set aside pre-tax money from your paycheck to pay for certain health care and dependent care expenses. You then submit your claims for eligible expenses and are reimbursed with tax-free dollars from your account(s) – *which can reduce your out-of-pocket health care and dependent care expenses by nearly 25%!*

Overview of Pre-Tax Reimbursement Accounts

For most participants, the HCSA/DCAP program provides a better tax benefit than is available to an individual taxpayer who itemizes medical expenses. The tax benefits of these pre-tax plans can be derived only from the participation in an employer-sponsored program.

- A **Health Care Spending Account** pays for eligible medical, dental and vision care expenses incurred by you and your dependents, that are not covered by your health care plan or dental care plan.

- A **Dependent Care Assistance Program** is used to reimburse you for dependent care expenses you incur in order to enable you (or you and your spouse) to work.

Basics of Pre-Tax Reimbursement

Participating in an optional HCSA or DCAP program can significantly reduce your federal and state income taxes. Through these plans, you may pay, on a pre-tax basis, for eligible health care and dependent care expenses.

- ✓ Annual enrollment takes place each November-December for the following calendar year. During this time you may enroll and decide how much to deposit (see annual deposits amount section) into each account. You cannot change your contribution until the next enrollment period unless you have a "change in family status."

- ✓ Your contributions to HCSA/DCAP will automatically be deducted in equal amounts each pay period from your paycheck on a pre-tax basis and sent to Sentinel Benefits, the administrator for this program.

- ✓ When you have incurred an eligible expense, you can either use your SmartFlex Debit Card (see SmartFlex Debit Card section, page 14) or submit a claim form for reimbursement to Sentinel Benefits.

- ✓ All claims are processed daily and reimbursements are deposited directly to your bank account. All reimbursement benefit payments come with an Explanation of Benefits to make reconciling your records simple and easy, and any information is kept strictly confidential.

Estimate your contributions to each plan carefully. The Internal Revenue Service requires that any money left in either account at the end of the plan year (use it or lose it rule).

Tax Benefits of HCSA or DCAP

Every dollar contributed to the HCSA or DCAP program is made on a pre-tax basis. The Commonwealth of Massachusetts deducts the amount that you selected directly from your "gross" wages. This means that plan contributions are deducted before federal and state taxes. A person in the 25% tax bracket, for example, would save approximately $250 for every $1,000 contributed to either of the pre-tax reimbursement programs.

As a result, your taxable income is less, meaning less money will be withheld from your pay for federal/state income taxes.

The following is an example of how a state employee could save money by participating in the pre-tax reimbursement program. Say an employee makes $30,000 each year, is in the 25% tax bracket and spends $6,000 expenses. These expenses include $2,000 in health care out-of-pocket and $4,000 in dependent care expenses. If this employee did not participate in any pre-tax plan his take-home pay, after-taxes and after paying for health care and dependent care expenses, is $16,500 a year.

However, if that same employee participated in both the HCSA and DCAP pre-tax programs, the money spent on the very same health care and dependent care expenses ($2,000/$4,000) would be deducted out of his paycheck **prior to federal or state withholdings**. Utilizing this method would provide additional "take-home" income of approximately $1,500 a year or $125 per month – *reducing the participant's health care and dependent care expenses by nearly 25%.* The following table illustrates the example:

Breakdown of Pay Check and Deductions	Not Participating in HCSA or DCAP Plan	Participating in HCSA or DCAP Plan
Gross Yearly Pay	**$30,000**	**$30,000**
Heath Care Reimbursement Account Election Annual Contribution (pretax)	$0	($2,000)
Dependent Care Assistance Program Annual Contribution (Pretax)	$0	($4,000)
Taxable Income	**$30,000**	**$24,000**
25% Federal Withholding	($7,500)	($6,000)
Yearly Health Care Expenses	($2,000 post-tax)	$2,000 (*Claims reimbursed*)
Yearly Day Care Expenses	($4,000 post-tax)	$4,000 (*Claims reimbursed*)
Net Available Income	**$16,500**	**$18,000**

Contributions to the HCSA/DCAP plan are not subject to tax at any time. Your year-end W-2 form from the Commonwealth of Massachusetts will properly notify all of the government agencies of your participation in the program.

Employees could potentially save up to $125 a month or $1,500 a year by participating in pre-tax plans.

Eligibility in a Pre-Tax Plan

Eligibility for Health Care Spending Account

Active state employees and their dependents eligible for health benefits with the GIC are eligible to participate in the HCSA program. Enrollment in one of the GIC's benefit plans is not required. New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment or two calendar months, whichever comes first. Claims incurred after your effective date are eligible for reimbursement. Employees must work at least 18.75 hours in a 37.5 hour workweek or 20 hours per 40-hour workweek. You may claim health care expenses under the HCSA plan for you, your spouse and your eligible tax dependents.

Eligibility for Dependent Care Assistance Program

All active state employees who work half-time or more and have employment-related expenses for a dependent child under the age of 13 and/or a disabled adult dependent are eligible for the DCAP program.

Enrollment in a Pre-Tax Plan

Enrollment for HCSA & DCAP

If you are a **new employee** with the Commonwealth of Massachusetts, you may elect to participate in the HCSA or DCAP programs. See your Payroll Coordinator for a HSCA or DCAP Enrollment/Change Form.

If you choose not to enroll as a **new employee**, you will be eligible to enroll in the HCSA or DCAP for the upcoming calendar year during **annual enrollment** in the fall, unless you have a "change in family status" (see making changes to your election). Enrollment for the HCSA or DCAP takes place each fall (typically November/December) for the upcoming tax year. To join the Plan during annual enrollment you must complete the HCSA or DCAP Enrollment/Change Form. This form is available on the GIC's website at www.mass.gov/gic or through your Payroll Coordinator.

Employees hired during the Plan year are eligible for DCAP on the first day of employment. Employees hired during the Plan year are eligible for HCSA after the GIC waiting period is satisfied. Enrollment forms must be submitted to your payroll coordinator within 30 days from your date of hire.

Annual Contribution Amount & Administrative Fee

The most important questions that you may have is "how much money should I contribute and how much the HCSA and DCAP programs cost?" **You must carefully estimate your contributions to the HCSA or DCAP plans, as the IRS requires that money not spent during the plan year be forfeited**.

The cost to administer these programs is paid for by each employee on a pre-tax basis. The monthly administrative fee for calendar year 2005 is $3.95 – for HCSA alone, DCAP alone or, should you choose to participate in both the HCSA and DCAP programs you only pay the $3.95 administration fee for both.

Participants should examine prior-year records to determine how much money you expended for health care and dependent care related expenses.

Health Care Spending Account (HCSA) 2005

The maximum amount that you may contribute for calendar 2005 to your HCSA is $2,000. The minimum is $500.

Dependent Care Assistance Program (DCAP) 2005

The Internal Revenue Service regulations limit the maximum amount that you may contribute to the program. The maximum is the lesser of $5,000 per year per family or 100% of the lowest paid spouse's income.

Remember, the amount you select will be deducted from your paycheck on a pre-tax basis in equal installments over the period of the plan year. If you become eligible for HCSA or DCAP during the year, you can still elect to deposit the full maximum amount for the partial year. Whatever amount you elect will be deducted in equal amounts each pay period for the remainder of the calendar year.

You will only be reimbursed for eligible expenses incurred while you are participating in the HCSA/DCAP plan and making deposits. You cannot be reimbursed for expenses you incurred before your effective date or after you have ceased making contributions to your account. It is a good idea to monitor the GIC's website for updated plan information.

Making Changes to Your Election

In order to comply with IRS regulations, you may only enroll in a plan, change your contribution or terminate your election *during the plan year* if you can demonstrate a qualified "**change in family status**." The following events are considered a valid change in status under IRS regulations:

- Change in legal marital status;
- Change in number of dependents;
- Change in employment status;
- Change in work schedule, which changes your eligibility for the program;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Significant change of residence or work-site; or
- Judgment, decree or order pertaining to child or spouse.

A change in election due to a "change in family status" must be requested, in writing, no later than 30 days after the "family status change." A "change in family status" request can be made by filling in this section of the HCSA/DCAP Enrollment/Change Form available on the GIC's website at www.mass.gov/gic, and submitting it to your Payroll Coordinator. You will need to provide a document verifying a change in status such as a marriage or birth certificate.

How to file a claim

As you incur qualified expenses, you may file a claim for reimbursement with Sentinel Benefits or immediately pay for the eligble expense with a SmartFlex Debit Card (details of the card can be found in "SmartFlex Debit Card Questions and Answers" (page 14). Sentinel Benefits is a third party administrator who adjudicates and processes all reimbursement claims on behalf of the GIC.

The SmartFlex Card is a simple and unique system that will help you maximize the benefits of your GIC Pre-Tax Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP). Through innovative technology, your SmartFlex Card puts your pre-tax account(s) on one card making access to your money for eligible expenses easy and immediate. Simply present your SmartFlex Card to any merchant that accepts Visa to make qualified purchases and your payment will automatically be transferred from the appropriate GIC Pre-Tax account.

To submit claims manually you must submit your claim using a **Health Care/Dependent Care Claim Form**. This form is available from your Payroll Coordinator or on the GIC's website at www.mass.gov/gic. All claims must be mailed or faxed to Sentinel Benefits with a copy of a paid receipt or an invoice with a canceled check, or other supporting documentation that proves payment.

Only expenses incurred while you are participating in the HCSA/DCAP are eligible for reimbursement. You must be an active participant in the plan (making deposits) at the time the expenses are incurred. An expense is incurred when you receive the treatment or service, or purchase the supply, not when you receive the bill or make payment.

You are permitted to make a claim for an eligible expense up to your total annual election at any time during the year, provided the expense was incurred while you are making deposits to your account.

When you submit eligible expenses for reimbursement, you may need to certify that the expense is not reimbursable from any other source. Also, you may only submit eligible health related claims for reimbursement from your HCSA, and dependent care expenses to your DCAP.

IMPORTANT: To be considered eligible for reimbursement, the expense must occur on or after the date you become a participant in the plan. An expense is incurred when you receive the treatment or service, purchase the supply, or order the items, NOT when you receive a bill or make a payment.

Eligible Dependents

The HCSA and DCAP programs allow you to be reimbursed for eligible out-of-pocket health care expenses incurred by you and/or your eligible dependents.

For the HCSA and DCAP programs, you may claim reimbursements for expenses incurred by your legal spouse (as determined in accordance with state law to the extent consistent with the federal Defense of Marriage Act), any individual who would qualify as a tax dependent of yours under IRS Code Part 152, and any child for whom you are required to provide health coverage pursuant to a Qualified Medical Support Order. Also, children of divorced parents are considered to be a dependent of both parents.

For purposes of the dependent care plan, an "eligible dependent" must be under age 13. However, if a dependent is mentally or physically handicapped, he or she will remain a qualified dependent for the dependent care irrespective of age.

Note: *In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed.*

Eligible Health Care Expenses

Many health care expenses not paid by your medical and dental plan can be reimbursed from your HCSA. Eligible expenses under a health care spending account are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program.
To be considered eligible, these expenses must be considered expenses under Section 213 (d) (1) of the Internal Revenue Code. Please refer to the Health Care Spending Account Eligible Expenses Section (page 10) of this document for a listing of the most common expenses.

IMPORTANT NOTE: Keep in mind that expenses such as insurance premiums may be deductible on Schedule A of your federal taxes but are not eligible for reimbursement through a health care spending account.

Medical care expenses include payments you make for the diagnosis, cure, mitigation, treatment, or prevention of disease, or treatment affecting any part or function of the body. They also include insulin, and medicines and drugs that require a prescription. In addition, over-the-counter items (i.e., those not requiring a prescription) are considered an eligible expense.

Eligible Dependent Care Expenses

Eligible dependent care expenses are defined as those that enable the participant and the participant's spouse to work or to look for work. Please see page 14 of this document for a listing of most common expenses. A more detailed explanation can be found in Treasury Publication 503 on the Internet at www.sentinelbenefits.com/flexchoice. The expenses must be necessary in order to permit you and/or your spouse (if married) to be gainfully employed.

If You Don't Use Your Entire Account by Year End

The IRS requires that any unused funds in participant accounts at plan year-end be forfeited. Further, you may not transfer unused money from one account to another. Each account must remain separate.

Since the IRS does not allow you to carry amounts from one plan year to another, nor for excess contributions to be refunded to you, it is very important that you estimate your contributions carefully.

To alleviate some concern about forfeitures, you are provided a 90-day grace period after the close of the plan year to submit all claims incurred in the prior plan year.

The HCSA/DCAP plan year-ends on December 31. You have until March 31st of the following year to submit claims. After the 90-day grace period expires, your account will be closed for the prior plan year.

Privacy Of Medical Records

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the health care spending account and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the health privacy policies of the plan.

When Does Coverage End?

If you choose not to enroll in HCSA or DCAP during open enrollment or during your first 30 days of employment you won't be able to enroll until the next open enrollment, unless you have a "change in status."

You must re-enroll each calendar year. The reimbursement account election applies for one calendar year only. In order to continue participation in the account, you must make a new reimbursement account election at each open enrollment.

What happens if I take an unpaid leave of absence?

If you elect to participate in a HCSA or DCAP and take an unpaid leave of absence or go off payroll for any reason your eligibility will cease. You will be able to submit claims for expenses that you incur on or before your last paycheck deduction. You should speak to your Payroll Coordinator to go over your options:

1) If you return to the payroll during the plan year you may re-enroll in the plans. Please see your Payroll Coordinator to re-enroll and submit an Enrollment/Change Form, "change in status" section. This form is available on the GIC's website at www.mass.gov/gic.

2) You may have the deductions for the period of your unpaid leave taken on a pre-tax basis from the last paycheck you receive prior to your leave, provided your paycheck is sufficient. If you elect this option, you may continue to submit expenses for reimbursement for eligible expenses incurred during your leave of absence.

3) You may choose not to contribute for the pay periods you will be on an unpaid leave of absence. If you elect this option, you will not be reimbursed for any expenses incurred during your unpaid leave of absence. Once you return from your leave of absence and your participation in the Plan is reinstated and you have made up the contributions for the period you were on leave, you will be able to submit expense incurred during your leave.

   BE ADVISED: This option (3) will apply if you do not submit the "Change in Status" form within 30 days of your leave of absence.

4) You may elect to continue to contribute to the account while on an unpaid leave of absence under COBRA by making direct payments on an after-tax basis. Complete a COBRA application available on the GIC's website at www.mass.gov/gic and contact Sentinel Benefits directly for billing information. (The amount billed to you would be for eligible expenses incurred during your leave of absence, but you will not save on your taxes by doing this.)

Should you return to active employment before the end of the calendar year, see your GIC Payroll Coordinator to re-enroll. Payroll deductions will be recalculated so that the annual election is deposited to your account by calendar year end.

If you did not continue coverage during your unpaid leave of absence, any expenses incurred while you were off the payroll will not be eligible for reimbursement from future deposits made to the account.

If You Terminate State Service During the Plan Year

If you should terminate your employment with the Commonwealth of Massachusetts, retire or be laid off, your participation in HCSA and DCAP will terminate at the end of the payroll period that includes your last day of work. You will only be able to submit claims for eligible health care expenses that were incurred on or before your last paycheck deduction up until the 90-day grace period (March 31st). In order to use your HCSA account **after** you terminate state service you have two options:

1) You may elect to continue to contribute to the HCSA account under COBRA by making direct payment on an after-tax basis. The HCSA COBRA application is available on the GIC's website at www.mass.gov/gic. The amount billed to you would include a 2% administrative fee. You must notify your Payroll Coordinator within 60 days of your termination date in order to take this option.

2) You may choose to contribute the deductions for the balance of the year taken from your last paycheck on a pre-tax basis. This option will permit you to save the taxes as if you were still on the Commonwealth payroll, however, you would need to contact your Payroll Coordinator at least two weeks prior to your last paycheck date in order to take this option.

Be advised. **HCSA:** If you choose neither of these options, you will not be reimbursed for any health related expenses incurred after your date of termination. **DCAP:** You may file claims for eligible dependent care expenses against your account balance for expenses you incur through December 31 if you have money left in your account.

If you are denied a benefit under the HCSA or DCAP (e.g. claim for reimbursement denial, eligibility for pre-tax benefits or election change) and you feel this denial was made in error you should proceed in accordance with the following claims review procedures.

Appeals Process

Step 1: *Notice is received from Sentinel.* If your claim is denied, you will receive written notice as soon as reasonably possible but no later than 30 days after receipt of the claim.

Step 2: *Review your notice carefully*. Once you have received your notice from the provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the plan service provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. The GIC has set up only one level of review. You should send your appeal to the GIC (P.O. Box 8747, Boston, Massachusetts 02114-8747, Telephone: 617-727-2310, Facsimile: 617-227-2681)

Please submit all information identified in the notice of denial as necessary to support your claim and any additional information that you believe would support your claim.

Step 4: *Written notice of approval or denial is received from the GIC.* You will be notified in writing of the decision. The notice will be sent no later than 30 days after receipt of the appeal by the GIC.

Health Care Spending Account Eligible Expenses

Professional Services

- Chiropodist
- Chiropractor
- Christian Science practitioner
- Dermatologist
- Dentist
- Gynecologist
- Neurologist
- Nursing
- Obstetrician
- Oculist
- Ophthalmologist
- Optician
- Optometrist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Psychiatrist
- Psychoanalyst
- Psychologist
- Registered Nurse
- Surgeon (except for cosmetic surgery)

Hospital Services

- Anesthetist
- Oxygen mask, tent
- Use of operating room
- X-ray technician

Medical Treatments

- Acupuncture
- Birthing Classes
- Blood transfusion
- Diathermy
- Electric shock treatments
- Hearing services
- Injections
- Insulin treatments
- Laser eye surgery
- Nursing
- Organ transplant
- Pre and post-natal care
- Psychotherapy
- Radium therapy
- Sterilization
- Ultra-violet ray treatments
- Vasectomy
- X-ray treatments

Laboratory Exams

- Blood tests
- Cardiographs
- Metabolism tests
- Spinal fluid tests
- Sputum tests
- Stool examination
- Urine analysis
- X-ray examinations

Dental Services

- Cleaning teeth
- Crowns / Root canals
- Dental x-rays
- Filling teeth
- Gum treatment
- Oral surgery
- Orthodontia (unless only for cosmetic purposes)

Equipment and Supplies

- Abdominal supports
- Ambulance hire
- Arches
- Artificial teeth, eyes
- Auto device for handicapped person, but not for travel to work
- Back supports
- Blood pressure monitor
- Braces
- Contact lenses, supplies
- Cost of installing stair-seat elevator for person with heart condition
- Crutches
- Elastic hosiery
- Eyeglasses
- Fluoridation unit in home

- Hearing aids
- Heating devices
- Home Vaporizer
- Invalid chair
- Iron lung
- Orthopedic shoes
- Prescriptions
- Repair of telephone equipment for the deaf
- Sacroiliac belt
- Special mattress and plywood bed boards for relief of spinal arthritis
- Splints
- Truss

Miscellaneous Health Related Expenses

- Alcoholism inpatient care
- Birth control pills or other birth control items prescribed by a physician
- Braille books (excess cost of Braille books over cost of regular editions)
- Convalescent home if for medical treatment
- Drug treatment center - inpatient care
- Fees paid to health institute of services prescribed by a physician to alleviate a physical or mental defect or illness
- Guide for blind person
- Kidney donor's or possible kidney donor's expenses
- Legal fees for guardianship of mentally ill spouse where commitment was necessary for medical treatment
- Nurse's board and wages, including Social Security
- Remedial reading for dyslexic child
- Sanitarium and similar institutions
- School cost for physically and mentally handicapped children
- Seeing eye dog and its maintenance
- Telephone-teletype costs and television adaptor for closed caption service for deaf person

Health Care Spending Account Ineligible Expenses

- Antiseptic diaper service
- Athletic club expenses
- Babysitting fees enabling you to make doctor's visits
- Boarding school fees paid for a healthy child while parent is recuperating from illness
- Bottled water bought to avoid drinking fluoridated city water
- Cosmetic surgery not medically necessary
- Cosmetic dentistry not medically necessary
- Cost of divorce recommended by a psychiatrist
- Cost of hotel room suggested for sex therapy
- Cost of trips for a change of environment to boost morale of ailing person
- Deductions from your wages for sickness insurance under state law
- Domestic help
- Funeral, cremation or burial, cemetery plot or monument
- Health programs offered by resort hotels, health clubs and gyms
- Marriage counseling fees
- Maternity clothes
- Medical bills for divorced spouse
- Patent medicine
- Premiums in connection with life insurance policies, paid for disability, double indemnity, or for waiver or premiums in the event of total and permanent disability
- Premiums in connection with policies for reimbursement of loss of earnings or a guarantee of a specific amount in the event of hospitalization
- Premiums for medical or dental insurance
- Scientology fees
- Special food or beverage substitutes
- Stem cell harvesting
- Tuition and travel expenses to send problem child to a particular school for change of environment
- Veterinary fees for pet
- Vitamins and dietary supplements that can be purchased over-the-counter without a prescription

Excluded OTC Items *(not reimbursable)*

These items are excluded primarily because they are for your general health and well-being.

Cosmetics
- Deodorants
- Face creams
- Hair removal treatments/waxes
- Lip balms
- Lotions/moisteners
- Mouthwashes
- Shampoos
- Soaps
- Suntan lotions
- Teeth whitening products
- Toiletries
- Toothpaste
- Vitamins
- Wrinkle reducers

Eligible OTC Items (*reimbursable with itemized receipt)*

These items are eligible primarily for the medical care and will reimburse reasonable quantities without a medical practitioner's note.

- Allergy medicines (e.g. Benadryl, Claritin)
- Anti-fungal medications
- Anti-itch medications
- Antihistamines
- Bandages / band aids
- Carpel tunnel wrist supports
- Cold medicines
- Cold Sore remedies
- Condoms
- Cough drops, throat lozenges, cough suppressants
- Decongestants
- First aid creams, diaper rash ointments and supplies
- Gastrointestinal aids (e.g. antacids, anti-diarrhea medicines, laxatives, nausea medications)
- Hemorrhoid creams / treatments
- Home Pregnancy Tests
- Ice packs / Heating pads
- Incontinence supplies
- Lice treatments
- Menstrual Cycle medications
- Motion sickness pills
- Nasal sprays/ strips for congestion
- Ointments for muscle/joint pain
- Ophthalmic products
- Pain relievers
- Dehydration liquids for children
- Sinus medications
- Sleeping aids
- Smoking cessation products
- Sunburn creams
- Suppositories
- Thermometers
- Toothache relievers
- Topical ointments for gingivitis
- Wart remover medications
- Yeast infection creams

Dual Purpose List

These items have both a medical purpose and a personal/cosmetic or general health purpose, which require a medical practitioner's note. *

Medical Supplies

- Acne treatments
- Chondroitin
- Fiber supplements
- Glucosamine
- Hair loss treatments
- Herbal medicines
- Homeopathic remedies
- Hormone therapies
- Remedies for snoring
- Pre-natal vitamins
- St. John's Wort
- Sunscreen
- Vitamins related to health condition
- Weight-loss drugs

Medical Equipment

- Air conditioner, if medically necessary for relief from allergy or difficulty breathing
- Reclining chair if prescribed by physician
- Wigs, if advised by physician because of hair loss from disease
- Clarinet lessons, if advised by dentist for treatment of tooth defects

This list is not a complete list, but is intended to provide a Health Care Spending Account participant with examples to help determine what Over-The-Counter (OTC) medications may be eligible for reimbursement. This list may change from time to time.

* This additional practitioner documentation must:

a. Be on the licensed medical practitioner's letterhead or prescription form;
b. Be dated within the current Plan Year;
c. Include a diagnosis stating the specific medical condition being treated;
d. Indicate that the product being purchased will directly impact this medical condition;
e. Include the licensed medical practitioner's signature;
f. Specify that the product will not be used for general health, cosmetic or personal reasons; and
g. Be included each time a claim for that product is submitted (along with a completed reimbursement claim form and itemized receipt.)

Dependent Care Assistance Program Eligible Expenses

Eligible expenses under a dependent care assistance program are defined as those that enable the participant and the participant's spouse to work or to look for work. They include the following:

1. Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center;

2. Caregivers for a disabled spouse or dependent who lives with the participant;

3. Babysitter;

4. Nursery schools; and

5. Household expenses provided that a portion of such expenses is incurred to ensure a qualifying dependent's well-being and protection.

Note: One stipulation imposed by the IRS is that the service provider cannot be an individual for whom a personal tax exemption may be claimed and, if a child of the participant or spouse, cannot be under the age of 19

Dependent Care Assistance Program Ineligible Expenses

Expenditures that may not be reimbursed from dependent care assistance program include the following:

1. Babysitting for social events;

2. Educational expenses;

3. Charges for overnight camp; and

4. Expenses that the participant will take as a child care tax credit on his or her income tax return.

SmartFlex Debit Card Questions and Answers

What is a SmartFlex Card?

Your SmartFlex card is a prepaid debit card to be used exclusively with your GIC Pre-Tax HCSA or DCAP program *(administered by Sentinel Benefits)*. This card is issued by and is the property of UMB Bank pursuant to a license from Visa U.S.A. Inc. The card is programmed with your specific annual health care spending or dependent care election so it knows how much money you are permitted to spend. **This amount can only be used for eligible health care or dependent care expenses.**

How does a SmartFlex Card work?

With SmartFlex, using your pre-tax dollars is easier than ever before. As long as the merchant or service provider accepts Visa, there's no need to pay cash upfront, mail in your receipts and then wait for reimbursement. Each time you use your card for eligible expenses, funds are automatically deducted from your GIC pre-tax account.

Where can I use my SmartFlex Card?

You can use your SmartFlex Card to pay for eligible HCSA/DCAP expenses only at qualified locations that accept Visa. Qualified HCSA locations include doctor's offices, dentist's offices, pharmacies, and hospitals. Qualified DCAP locations include day care centers, day camps and nursery schools. Your card cannot be used at non-qualified locations such as gas stations, restaurants or convenience stores.

Should I select "Debit" or "Credit" at the cashier?

When making a purchase with a keypad or screen, select "**Credit**." *(The card does not have a PIN and you must select "credit" and sign for the transaction.)* When making a purchase without a keypad or screen, give your card to the clerk and sign the receipt. If you're asked whether it's a credit or debit, say "Credit." (No PIN number is required. If "debit" is selected, your purchase will be declined.)

Can I get cash out of an ATM or at the cashier with this card?

No. You cannot get cash with this card. This card may only be used to purchase **eligible expenses** pursuant to the GIC's Pre-Tax Programs. See your pre-tax participant handbook for a list of eligible expenses.

What if my provider does not accept Visa?

Use another form of payment and submit the GIC pre-tax HSCA/DCAP **Claim Form** along with your receipt(s) to Sentinel Benefits for reimbursement. Claim forms are available on the GIC website.

Can I purchase eligible items online?

Yes. You can use this card online to purchase eligible expenses. Keep your itemized receipt(s) after you make the purchase. You may be required to submit itemized receipts to verify that the transaction was for eligible expenses.

What eligible expenses can the card be used for?

Please refer to your plan description handbook for a detailed list of eligible expenses. A sample list of expenses covered by the SmartFlex card include:

Health Care: *Prescription drug copays, doctor office copays, health plan deductibles, approved over-the-counter drugs, eyeglasses, dental costs not covered by your dental plan (including LASIK surgery, eyeglasses, contacts, orthodontia), hospital visits or copays, chiropractic services and smoking-cessation programs*

Dependent Care: *day care and nursery school, before and after school care, summer day camp (for dependent children under 13), care for mentally or physically handicapped dependents over age 13.*

Can I use my SmartFlex Card for eligible Over-The–Counter (OTC) eligible expenses?

Currently, OTC eligible expenses must be submitted using the HCSA claim form along with your receipts. You will be able to use your SmartFlex card for these transactions in the future.

How do I check the funds that are in my account?

To check your SmartFlex account funds and recent activity, contact Sentinel Benefits Client Services toll-free at 888.762.6088. This information is also available at www.sentinelbenefits.com/flexchoice. Your password is your birth date in the following format: MMDDYYYY.

Do I need to keep my receipts?

Yes. Although you may use your card to pay for eligible expenses, such as ordering mail-order prescription drugs, the Internal Revenue Service still requires you to substantiate any claims paid from your account. You may be asked by Sentinel Benefits to submit receipts on benefits paid using your SmartFlex Card.

What happens if I don't send in receipts to Sentinel Benefits when asked?

If Sentinel Benefits believes that proof of purchase is necessary and you do not comply with their request, your SmartFlex Card privileges may be suspended. You will receive adequate warning should this action be necessary.

What if a claim I paid with my SmartFlex card is later found to be ineligible?

Sentinel Benefits will ask you to pay the ineligible amount by either sending in a personal check or by going **online at www.motivano.com** and using a personal credit card to pay the ineligible amount in question. Instructions regarding your payment options will be mailed to your home. If you do not reimburse the plan for ineligible payments, your card may be suspended.

What if I don't have enough money on my SmartFlex card to pay for my purchase?

The transaction will be declined if your available account balance is insufficient to pay for your entire purchase. You will need to pay for your purchase either with cash, a personal check or credit card and then submit a completed claim form with your receipt to Sentinel Benefits for processing. You may encounter this situation at the end of the plan year when your election amount is almost depleted.

What if my card does not work at a qualified location or the card was "declined"?

You may have to pay with another form of payment. The failure could be due to any of the following reasons. Please contact Sentinel Benefits for additional details:

- the purchase cannot be determined as an eligible expense.
- you included non-eligible expenses with your eligible expenses. (Try the transaction again with the eligible expenses only.)
- there is not enough money in your account to completely cover the expense.

Can I use my SmartFlex Prepaid Card if I receive a health care bill with a "Patient Balance Due?"

Yes, as long as you have sufficient funds in your account and your health care provider accepts Visa you may use the SmartFlex card to pay such bills. Just write your SmartFlex card number on the health care bill and return it to your health care provider.

How do I obtain a SmartFlex Card?

You may obtain a SmartFlex Card by completing a **SmartFlex Debit Card Enrollment Form** and sending it to Sentinel Benefits. Sentinel Benefits will automatically deduct the annual $18.00 fee from your DCAP/HCSA election account in your first annual payroll deduction. If you re-enroll in the plan in the following year and already have a SmartFlex Card, Sentinel Benefits will deduct its annual fee for the card at the beginning of the Plan Year.

May I obtain a card for my spouse?

Yes. You may obtain a card for your spouse. The cost to order an additional card is $5.00 per card. The fee is automatically deducted from your account when the card is ordered. Simply complete the **SmartFlex Debit Card Enrollment Form and** send it into Sentinel Benefits.

Are the fees I pay for my SmartFlex Card paid on a pre-tax basis?

Yes. The fee you pay for a SmartFlex Card and for an additional card for your spouse or dependent over age 18 is qualified under the plan making the SmartFlex Card a pre-tax expense. For example, if you sign

up for the HSCA Program, choose to contribute $1,000 for the year and sign up for the SmartFlex Card, Sentinel will automatically deduct the $18.00 card fee from your pre-tax contributions – leaving your account with $982 for eligible HCSA expenses.

How do I activate my SmartFlex Card once I have received it?

The SmartFlex Card is a signature-based card. There is no PIN required. The card will automatically be activated when you sign for your first purchase. When you activate the card by signing for your first purchase, you agree to the following:

- Agree to the terms and conditions outlined in the Cardholder Agreement that was sent to you when you received your card.
- *Acknowledge that your funds are authorized only for the payment of eligible DCAP/HCSA expenses as outlined in the Commonwealth's plan document.*
- Certify that these funds have not been and will not be reimbursed under any other plan coverage.
- Will submit any required documentation to the Plan Administrator as requested.

How do I cancel the SmartFlex Card?

If you no longer want the SmartFlex Card, you may cancel it by contacting Sentinel Benefits Client Services at 888.762.6088. You will not receive a refund of the fee for the SmartFlex Card for any period of the plan year remaining.

What if I was charged the wrong amount on my SmartFlex Card?

Contact Sentinel Benefits Client Services immediately toll-free at 888.762.6088. A representative will assist you in determining the appropriate resolution.

What if my card is lost or stolen?

Contact Sentinel Benefits Client Services immediately toll-free at 888.762.6088. Visa provides protection for fraudulent use of your card.

Contact Information

Plan Administrator: Sentinel Benefits

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